Unannounced Care Inspection Report
14 October 2016

Ailsa Lodge

Type of Service: Nursing Home
Address: 6 Killaire Avenue, Carnalea Avenue, Bangor, BT19 1EW
Tel no: 028 9145 2225
Inspector: Sharon Mc Knight

1.0 Summary

An unannounced inspection of Ailsa Lodge took place on 14 October 2016 from 10.00 to 17.30.

The inspection sought to assess progress with any issues raised during and since the last inspection and to determine if the home was delivering safe, effective and compassionate care and if the service was well led.

Is care safe?

The systems to ensure that care was safely delivered were reviewed. We examined staffing levels and the duty rosters, recruitment practices, staff registration status with their professional bodies and staff training and development. Through discussion with staff we were assured that they were knowledgeable of their specific roles and responsibilities in relation to adult safeguarding.

Two areas for improvement were identified in the delivery of safe care. The first was in relation to the recruitment processes and the attainment of a health assessment for candidates. With regard to the interface between complaints and potential safeguarding issues we recommended that advice should be sought from the appropriate health and social care trust prior to commencing the complaints process.

Is care effective?

We reviewed the systems and processes in place which support effective care delivery.

A comprehensive, holistic assessment of patients' nursing needs was commenced at the time of admission to the home and a range of care plans generated to the meet the individual needs of the patient. Personal care records evidenced that records were maintained to evidence care delivery. Following a review of care records one area for improvement was identified; a recommendation was made.

We examined the systems in place to promote effective communication between staff and were assured that these systems were robust. Staff advised that there was effective teamwork; each staff member knew their role, function and responsibilities

Patients, relatives and staff spoken with, and those who completed questionnaires, were of the opinion that the care delivered was effective.

Is care compassionate?

Observations of care delivery evidenced that patients were treated with dignity and respect. Staff were observed responding to patients' needs and requests promptly and cheerfully. Numerous compliments had been received by the home from relatives and friends of former patients. Systems were in place to ensure that patients and relatives, were involved and communicated with regarding issues affecting them.

We met with the staff member responsible for the provision of activities. A review of photographs evidenced a wide range of activities that had taken place recently. A number of the crafts made by patients were displayed in the lounge of the home. Patients commented positively with regard to the activities and reported that they looked forward to them. Patients spoken with commented positively in regard to living in the home.

Is the service well led?

There was a clear organisational structure evidenced within Ailsa Lodge and staff were aware of their roles and responsibilities. A review of care observations confirmed that the home was operating within the categories of care for which they were registered and in accordance with their Statement of Purpose and Patient Guide.

Staff spoken with were knowledgeable regarding the line management structure within the home and who they would escalate any issues or concerns to; this included the reporting arrangements when the registered manager was off duty. There were systems in place to monitor the quality of the services delivered.

We sought relative and staff opinion on leadership in the home via questionnaires. All of the relatives and staff were either very satisfied or satisfied that the service was well led.

This inspection was underpinned by The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, The Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015.

1.1 Inspection outcome

	Requirements	Recommendations
Total number of requirements and recommendations made at this inspection	0	3

Details of the Quality Improvement Plan (QIP) within this report were discussed with Mrs Jacqueline Robinson, registered manager/responsible person, as part of the inspection process. The timescales for completion commence from the date of inspection.

Enforcement action did not result from the findings of this inspection.

1.2 Actions/enforcement taken following the most recent care inspection

The most recent inspection of the home was an unannounced care inspection undertaken on 7 January 2016. Other than those actions detailed in the QIP there were no further actions required to be taken. Enforcement action did not result from the findings of this inspection.

RQIA have also reviewed any evidence available in respect of serious adverse incidents (SAI's), potential adult safeguarding issues, whistle blowing and any other communication received since the previous care inspection.

There were no further actions required to be taken following the most recent inspection.

2.0 Service details

Registered organisation/registered person: Ailsa Lodge/Jacqueline Robinson	**Registered manager:** Jacqueline Robinson
Person in charge of the home at the time of inspection: Jacqueline Robinson	**Date manager registered:** 1 April 2005
Categories of care: NH-I, NH-PH, NH-PH(E), NH-TI	**Number of registered places:** 41

3.0 Methods/processes

Prior to inspection we analysed the following records:

- notifiable events since the previous care inspection
- the registration status of the home
- written and verbal communication received since the previous care inspection
- the returned quality improvement plan (QIP) from the previous care inspection
- the previous care inspection report.

During the inspection we met with 12 patients individually and with the majority of others in small groups, one registered nurse, six care staff and one patient's relatives.

The following information was examined during the inspection:

- three patient care records
- staff duty roster for week commencing 10 October 2016
- staff training records
- staff induction records
- staff recruitment records
- records of staff NMC/NISCC registration
- complaints and compliments records
- incident and accident records
- records of audit
- records of staff meetings
- reports of the monthly quality monitoring visits.

4.0 The inspection

4.1 Review of requirements and recommendations from the most recent inspection dated 7 January 2016

The most recent inspection of the home was an unannounced care inspection. The completed QIP was returned and approved by the care inspector and will be validated during this inspection.

4.2 Review of requirements and recommendations from the last care inspection dated 7 January 2016.

Last care inspection statutory requirements		Validation of compliance
Requirement 1 **Ref:** Regulation 14(2)(c) **Stated**: Second time **To be completed by:** 7 February 2016	The registered person shall ensure as far as reasonably practicable that unnecessary risks to the health and safety of patients are identified and so far as possible eliminated. This refers specifically to the following: • The presence of unlabelled cleaning products and air fresheners in unlocked cupboards in sluices, hairdressing room and throughout the home.	**Met**
	Action taken as confirmed during the inspection: We observed cleaning products in the domestic stores on the ground and first floor and on one trolley. All of the products were clearly labelled. Discussion with the housekeeper evidenced that staff were aware of the importance of ensuring cleaning products were labelled. This requirement has been met.	

Last care inspection recommendations		Validation of compliance
Recommendation 1 **Ref**: Standard 23, criterion 3 **Stated:** First time **To be Completed by:** 7 February 2016	A validated pressure ulcer grading system should be used for patients who have skin damage and an appropriate treatment plan implemented.	**Met**
	Action taken as confirmed during the inspection: We were informed by the deputy manager that there were no patients with pressure ulcers in the home. The assistant manager and a registered nurse spoken with were knowledgeable regarding the grading of pressure ulcers and the importance of ensuring appropriate treatment plans were in place. The assistant manager confirmed that a referral system was in place to ensure patients had access to tissue viability services from the local healthcare trust as required. This recommendation has been met.	

4.3 Is care safe?

The assistant manager confirmed the planned daily staffing levels for the home and advised that these levels were subject to regular review to ensure the assessed needs of the patients were met. They provided examples of the indicators they used to evidence that there was sufficient staff to meet the needs of the patients.

A review of the staffing roster for week commencing 10 October 2016 evidenced that the planned staffing levels were adhered to. In addition to nursing and care staff, staffing rosters confirmed that administrative, catering, domestic and laundry staff were also on duty daily. A member of staff was identified to provide activities for the patients. Nursing and care staff spoken with were satisfied that there were sufficient staff to meet the needs of the patients. We also sought staff opinion on staffing via questionnaires; ten were returned following the inspection. All of the respondents answered 'yes' to the question "Are there sufficient staff to meet the needs of the patients?"

Patients and relatives spoken with during the inspection commented positively regarding the staff and care delivery. We sought relatives' opinion on staffing via questionnaires; five completed questionnaires were returned. All of the respondents indicated that staff had enough time to care for their relative.

Staff spoken with were aware that a nurse was identified to be in charge of the home when the registered manager was off duty. The nurse in charge of the home was clearly identified on the staffing roster. The registered manager confirmed that a competency and capability assessment was completed with all registered nurses who were given the responsibility of being in charge of the home in the absence of the manager.

A review of two personnel files evidenced that were there were safe systems in place for the recruitment and selection of staff. The personnel files reviewed did not contain any information with regard to an assessment of the candidate's health. A recommendation was made. Access NI checks was reviewed and evidenced that the certificate had been checked prior to the candidate commencing employment.

Discussion with the administrator and the registered manager, and a review of records, evidenced that the arrangements for monitoring the registration status of nursing and care staff were appropriately managed. Systems were in place to support newly employed staff with the Northern Ireland Social Care Council (NISCC) registration process.

Discussion with the assistant manager and staff and a review of records evidenced that newly appointed staff completed a structured orientation and induction programme at the commencement of their employment. One completed induction programme was reviewed. The programme included a written record of the areas completed and the signature of the person supporting the new employee. On completion of the induction programme the registered manager signed the record to confirm that the induction process had been satisfactorily completed. One staff member spoken with confirmed that they worked alongside experienced staff until they felt confident to care for the patients unsupervised. Newly appointed staff were given the opportunity to provide feedback to the management of the home, via a questionnaire, on the usefulness of their induction. The registered manager explained that this reflective feedback was used to review the induction process in terms of how effective staff found it. This was recognised as good practice.

Mandatory training was provided by the home via face to face, trainer led sessions. Training were often provided in sessions referred to as "lunch and learn" when staff were provided with lunch during which training was delivered. A review of the records evidenced that this approach to training was well supported by staff.

The registered manager had systems in place to monitor staff attendance and compliance with training. These systems included a training matrix to facilitate an overview and the signing in sheets from each training to evidence staff attendance. A review of attendance at mandatory training evidenced good compliance; for example 100% of staff have attended safeguarding training and infection prevention in 2016. A copy of the content of training was available in the home. Staff spoken with confirmed that they were provided with a range of training. Staff were of the opinion that the training provided was relevant to their role and responsibilities within the home. Training opportunities were also provided by the local health and social care trust.

Discussion with the registered manager and staff confirmed that there were systems in place to ensure that staff received support and guidance and to monitor staff performance, if required. Staff were coached and mentored through one to one supervision, competency and capability assessments and annual appraisals.

Staff were knowledgeable about their specific roles and responsibilities in relation to adult safeguarding. A review of the complaints record identified one complaint regarding staff communication with a patient and this had been reported to the patient's care manager. We discussed the nature of the complaint with the registered manager and it was agreed that where a complaint has the potential to be a safeguarding issue, the registered manager would seek advice from the appropriate health and social care trust prior to commencing the complaints process. A recommendation was made. Complaints are further discussed in section 4.6.

Review of three patient care records evidenced that a range of validated risk assessments were completed as part of the admission process to accurately identify risk and inform the patient's individual care plans.

Discussion with the registered manager, assistant manager and a review of records evidenced that systems were in place to ensure that notifiable events were investigated and reported to the relevant bodies. A random selection of accidents and incidents recorded since the previous inspection evidenced that generally these had been appropriately notified to RQIA in accordance with Regulation 30 of The Nursing Homes Regulations (Northern Ireland) 2005. A post fall evaluation was completed following every fall and considered environmental factors, patients ability to call for assistance and the patients level of mobility. Through discussion we clarified what was required to be notified to RQIA with regard to falls. An analysis of accidents to identify any trends or patterns was completed monthly.

A general inspection of the home was undertaken to examine a random sample of patients' bedrooms, lounges, bathrooms and toilets. The majority of patients' bedrooms were personalised with photographs, pictures and personal items. The home was fresh smelling, clean and appropriately heated. All of the responses we received in the returned questionnaires confirmed that this was normal for the home.

Fire exits and corridors were observed to be clear of clutter and obstruction.

There were no issues identified with infection prevention and control practice.

Areas for improvement

A pre- employment health assessment should be obtained as part of the recruitment process.

Where a complaint has the potential to be a safeguarding issue advice should be sought from the appropriate health and social care trust prior to commencing the complaints process.

Number of requirements	0	Number of recommendations	2

4.4 Is care effective?

A review of three patient care records evidenced that a comprehensive, holistic assessment of patients' nursing needs was commenced at the time of admission to the home and a range of care plans generated to the meet the individual needs of the patient. As previously discussed a range of validated risk assessments were completed as part of the admission process. Personal care records evidenced that records were maintained to evidence care delivery. For example, a review of repositioning records evidenced that patients were repositioned regularly.

A review of one patient's care plan evidenced that it had not been updated following a reassessment by a speech and language therapist (SALT). The reassessment was referenced in the recorded evaluation of the care plan but the care plan had not been updated to reflect the changes to the prescribed care. A recommendation was made.

There was evidence in the care records that care plans were being evaluated. However it was unclear which evaluation related to which care plan. For example in one care record the registered nurse had included an update of the patient's condition and recorded "no change to care plan." In another care record a registered nurse had not commented on the patient's condition, all they had recorded was "no change to care plan." Both patients had a number of

care plans in place. We discussed the evaluation of care plans with the registered manager and assistant manager. It was agreed that they would review the recording of care plan evaluations to ensure that records reflected that all care plans were being reviewed regularly. Care plan evaluations should include how the registered nurse has concluded that the care plan continues to meet the needs of the patient.

Care records reflected that, where appropriate, referrals were made to healthcare professionals such as tissue viability nurse specialist (TVN), SALT and dieticians. The assistant manager confirmed that care management reviews were arranged by the relevant health and social care trust. These reviews were generally held annually but could be requested at any time by the patient, their family or the home.

Discussion with the registered manager, assistant manager and staff evidenced that nursing and care staff were required to attend a handover meeting at the beginning of each shift. Staff were aware of the importance of handover reports in ensuring effective communication and confirmed that the shift handover provided information regarding each patient's condition and any changes noted.

The registered manager confirmed that staff meetings were held regularly and records were maintained of the staff who attended, the issues discussed and actions agreed. The most recent staff meeting was held on 31 August 2016.

Staff advised that there was effective teamwork; each staff member knew their role, function and responsibilities. All grades of staff consulted clearly demonstrated the ability to communicate effectively with their colleagues and other healthcare professionals. Staff confirmed that if they had any concerns, they would raise these with the assistant manager or the registered manager.

Patients spoken with commented positively in regard to the care they received. The following comments were provided:

"They simply couldn't do anything more…"
"You only have to ask, nothing is any bother."
"They're all great. They allow me to paint, I make an awful mess and they never complain."

Observation of the mid-day meal confirmed that dining tables were attractively set, a range of condiments were available and patients, including patients who required a modified diet, were afforded a choice of meals at mealtimes. Meals were delivered on trays to patients who choose not to come to the dining room. The meal was appropriately covered and accompanied by condiments and the patients preferred choice of drink, for example; juice or milk were on the trays.

We observed that tea and coffee making facilities were available for relatives and visitors in the front reception hall.

Areas for improvement

Following a reassessment of patients' needs, care plans should be reviewed and updated to accurately reflect the prescribed care.

Number of requirements	**0**	**Number of recommendations**	**1**

4.5 Is care compassionate?

Observations throughout the inspection evidenced that there was a calm atmosphere in the home and staff were quietly attending to the patients' needs. Staff were observed responding to patients' needs and requests promptly and cheerfully, and taking time to reassure patients as was required from time to time. Staff spoken with were knowledgeable regarding patients' likes and dislikes and individual preferences.

Patients spoken with commented positively in regard to the care they received and were happy in their surroundings. Those patients who were unable to verbally express their views were observed to be appropriately dressed and were relaxed and comfortable. Observation of care delivery confirmed that patients were assisted appropriately, with dignity and respect, and in a timely manner.

Patients were observed to be sitting in the lounges, or in their bedroom, as was their personal preference. The staff confirmed that whilst socialisation between patients was promoted, each had a choice as to how they spent their day and where they preferred to sit throughout the day.

Relatives confirmed that they were made to feel welcome into the home by all staff. They were confident that if they raised a concern or query with the registered manager or staff, their concern would be addressed appropriately.

Numerous compliments had been received by the home from relatives and friends of former patients. The following are some comments recorded in thank you cards received:

"Your endless patience, your sensitivity and your tender care at all times was very much appreciated, also your kindness and inspiration of strength when needed by myself."

"…to thank you for the unfailing care and attention you have my mother in her last 2 years."

"I address you as friends because over the past three months you have endeared yourselves to our whole family by the outstanding level of care lavished on…"

We discussed how the registered manager consulted with patients and relatives and involved them in the issues which affected them. They explained that they had regular, daily contact with the patients and any visitors and was available, throughout the day, to meet with both on a one to one basis if needed. Patients spoken with confirmed that they knew who the registered manager was and that she was regularly available in the home to speak with.

Quality assurance questionnaires were also issued to a number of patients and relatives monthly; management explained that the response rate varies from month to month but often was low. When the completed questionnaires were returned the comments and/or areas for improvements were logged and when addressed the action taken was recorded. It was good to note that any expressions of dissatisfaction were escalated and recorded as complaints.

We met with the staff member responsible for the provision of activities. The entrance to the home was decorated with a harvest theme and the carer explained that many of the activities were seasonally themed; for example harvest, remembrance Sunday, Christmas. The planned activities were displayed in the entrance hall to inform visitors and relatives of what was taking place and when. A review of the photographs evidenced a wide range of activities that had taken place recently. A number of the crafts made by patients were displayed in the lounge of the home. The activity carer explained that patient's religious and spiritual needs were also

included in the activities. Patients were also visited by clergy and members of the local churches. Patients spoken with commented positively with regard to the activities and reported that they looked forward to them. Patients spoken with in their rooms were aware of the activities and confirmed that they would attend those that interested them.

Ten questionnaires were issued to relatives; five were returned prior to the issue of this report. All of the respondents were either satisfied or very satisfied with the care their loved ones were receiving.

Ten questionnaires were issued to nursing, care and ancillary staff; all of them were returned prior to the issue of this report. The respondents indicated that they were satisfied or very satisfied with the delivery of safe, effective and compassionate care and that the service was well led. No additional comments were included.

Areas for improvement

No areas for improvement were identified within the domain of compassionate care.

Number of requirements	0	Number of recommendations	0

4.6 Is the service well led?

The certificate of registration issued by RQIA and the home's certificate of public liability insurance were appropriately displayed in the foyer of the home. Discussion with staff, a review of care records and observations confirmed that the home was operating within the categories of care registered.

Discussion with the registered manager and staff evidenced that there was a clear organisational structure within the home. Staff spoken with were knowledgeable regarding the line management arrangements within the home and who they would escalate any issues or concerns to; this included the reporting arrangements when the registered manager was off duty. Discussions with staff also confirmed that there were good working relationships.

The registered manager explained that they had regular contact with the patients and were available, throughout the day, to meet with them if needed. Patients spoken with were aware of who the registered manager was and that she was available in the home to speak with. We also sought relative and staff opinion on leadership in the home via questionnaires. All of the relatives and staff were either very satisfied or satisfied that the service was well led.

Discussion with the registered manager and review of the home's complaints record evidenced that complaints were managed in accordance with Regulation 24 of the Nursing Homes Regulations (Northern Ireland) 2005 and the DHSSPS Care Standards for Nursing Homes 2015. Patients and staff confirmed they were confident that management would manage any concern raised by them appropriately.

A record of complaints was maintained. The record included the date the complaint was received, the nature of the complaint and details of the investigation. There were numerous thank you cards and letters received from former patients and relatives; examples of these have been included in the previous domain.

There were arrangements in place to receive and act on health and safety information, urgent communications, safety alerts and notices; for example from the Northern Ireland Adverse Incident Centre (NIAIC).

The registered manager discussed the systems she had in place to monitor the quality of the services delivered. A programme of audits was completed on a monthly basis. Areas for audit included the environment, bed rail safety, care records and the occurrence of accidents and incidents. Records evidenced that where an area for improvement was identified there was evidence of re-auditing to check that the required improvement had been completed.

As the registered manager/provider explained that, as they were in day to day operation of the home an unannounced monthly visit, as described in regulation 29 of the Nursing Homes Regulation (Northern Ireland) 2005, was not completed. They explained that in order to ensure that the home delivers services effectively on a day to day basis they complete a monthly report. The report includes a review of the environment, accident and incidents, complaints, staff development and patients, relatives and staff comments. The reports were available but were not reviewed as part of this inspection.

Areas for improvement

No areas for improvement were identified during the inspection.

Number of requirements	**0**	**Number of recommendations**	**0**

5.0 Quality improvement plan

Any issues identified during this inspection are detailed in the QIP. Details of the QIP were discussed with Mrs Jacqueline Robinson, registered manager/responsible person, as part of the inspection process. The timescales commence from the date of inspection.

The registered provider/manager should note that failure to comply with regulations may lead to further enforcement action including possible prosecution for offences. It is the responsibility of the registered provider to ensure that all requirements and recommendations contained within the QIP are addressed within the specified timescales.

Matters to be addressed as a result of this inspection are set in the context of the current registration of the nursing home. The registration is not transferable so that in the event of any future application to alter, extend or to sell the premises RQIA would apply standards current at the time of that application.

5.1 Statutory requirements

This section outlines the actions which must be taken so that the registered provider meets legislative requirements based on The Nursing Homes Regulations (Northern Ireland) 2005.

5.2 Recommendations

This section outlines the recommended actions based on research, recognised sources and The Care Standards for Nursing Homes 2015. They promote current good practice and if adopted by the registered provider/manager may enhance service, quality and delivery.

5.3 Actions to be taken by the registered provider

The QIP should be completed and detail the actions taken to meet the legislative requirements and recommendations stated. The registered provider should confirm that these actions have been completed and return the completed QIP to nursing.team@rqia.org.uk for assessment by the inspector.

It should be noted that this inspection report should not be regarded as a comprehensive review of all strengths and areas for improvement that exist in the service. The findings reported on are those which came to the attention of RQIA during the course of this inspection. The findings contained within this report do not exempt the registered provider from their responsibility for maintaining compliance with the regulations and standards. It is expected that the requirements and recommendations outlined in this report will provide the registered provider with the necessary information to assist them to fulfil their responsibilities and enhance practice within the service.

Quality Improvement Plan

Statutory requirements: No requirements were made as a result of this inspection.

Recommendations	
Recommendation 1 **Ref**: Standard 38.3 **Stated:** First time **To be completed by:** 11 November 2016	It is recommended that a pre- employment health assessment is obtained as part of the recruitment process. **Ref section 4.3**
	Response by registered provider detailing the actions taken: A new Health Assessment pro Forma has been sourced and will be used for all new employees.
Recommendation 2 **Ref**: Standard 13 **Stated:** First time **To be completed by:** 11 November 2016	It is recommended that where a complaint has the potential to be a safeguarding issue advice is sought from the appropriate health and social care trust prior to commencing the complaints process. **Ref section 4.3**
	Response by registered provider detailing the actions taken: The Complaints Manager has noted this recommendation and each complaint will be assessed as to whether there is a safeguarding issue and the result of the assessment recorded for each complaint.
Recommendation 3 **Ref**: Standard 4 **Stated:** First time **To be completed by:** 11 November 2016	It is recommended that when patients' needs are reassessed care plans should be reviewed and updated to accurately reflect the prescribed care. **Ref section 4.4**
	Response by registered provider detailing the actions taken: This has been noted and escalated down to all Staff Nurses who will accurately denote to reflect any re-assessment and its outcome.

Please ensure this document is completed in full and returned to nursing.team@rqia.org.uk from the authorised email address

The Regulation and Quality Improvement Authority
9th Floor
Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT

Tel 028 9051 7500
Fax 028 9051 7501
Email info@rqia.org.uk
Web www.rqia.org.uk
@RQIANews